

Opportunity for integration lost in creation of new roles

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Efforts to reorganise pharmacy to encourage the provision of medicines management and patient care created new roles for pharmacists but they remained outside mainstream primary care.

The 2000 national plan for pharmacy – *Pharmacy in the Future* – was published and was hailed as a victory for community pharmacy in England.¹ After years of lobbying, the advocates of re-professionalisation had, at last, convinced the government to create new roles for pharmacists.² No longer would they be paid primarily for dispensing, but new fees would be introduced to encourage the provision of medicines management services to patients.

Opportunity lost

However, the extended roles gained were an opportunity lost because the location, organisation and remuneration of community pharmacy remained outside mainstream primary care. Despite the reforms, pharmacists performing their new roles had to do so within the confines of their own premises. There were few plans for co-location, joint working, combined incentives, or the sharing of patient information with GPs.

The re-professionalisation lobby had been appeased but large-scale opportunities for real, game-changing progress on the ground had been lost. Therefore, the age-old split between the prescribing doctor and the community pharmacist remained.³ For a Labour government keen on modernisation, *Pharmacy in the Future* supported a profession keen to

KEY EVENTS

- **1986** Holloway and colleagues write on re-professionalisation for community pharmacists due to the changing role of dispensing
- **1986** Nuffield Report concludes that pharmacy has a distinctive and indispensable contribution to make to patient care
- **1990** Hepler and Strand publish paper on pharmaceutical care, which shifts focus away from dispensing towards patient care
- **2000** The national plan for pharmacy – *Pharmacy in the Future* – was published outlining long awaited reforms for the profession
- **2013** *Now or Never* report published, which outlines ideas for future for pharmacy shaped by the Director of Policy at the Nuffield Trust, Dr Judith Smith, and colleagues

evolve, but represented a failure to deliver system-wide revolutionary change.

Prior to the 1991 reforms, health service policy in the UK was always shaped with the help of a specially initiated Royal Commission, which would seek to collect and analyse opinions from all interested parties. With the introduction of the NHS market and GP fund-holding in 1991, a new era of creating policy ideas was born.⁴

Policy wonks

From the early 1990s onwards, “policy wonks” could directly influence NHS reforms without widespread debate. In terms of policy making, new Labour’s plans for pharmacy were part old school, part new approach. For instance, policies taken from the Nuffield Report and *Pharmacy In A New Age* were in keeping with the traditional approach of prolonged, open discussion about an appropriate policy direction.

Hepler and Strand’s concept of pharmaceutical care, which underpinned much of the thinking in the 2000 plan, could be seen as the work of policy wonks whose ideas were implementable

without input from the medical and allied professions.⁵ Therefore, pharmacy reform became a mixture of different policy ideas, created by competing and often unrelated parties, which the Labour government presented as a coherent, modernising whole.

Moreover, the conclusion could be drawn that much of the thinking behind *Pharmacy in the Future* was devised by pharmacists for pharmacists, primarily for the benefit of pharmacists. Indeed, the policy document focused little on patients and did little to overcome the important barriers between GPs and community dispensers, which hampered inter-professional liaison and working.

Artificially split

In a system where prescribers and dispensers were artificially split, real reforms were required in terms of locat-

ing doctors and pharmacists in the same buildings, working within the same budgets, within a wider primary care team. Indeed, the time had come to move away from the roles of prescriber and dispenser in order to introduce new systems of pharmaceutical care. However, in 1990 Hepler and Strand wrote: "Pharmacy today appears as a collection of disputatious factions and splinter groups, still 'a profession in search of a role,' but now a profession unable to choose from a bewildering variety of functions and unable to overcome a variety of 'barriers to clinical practice'".

Although written about the American system, Hepler and Strand's quote also reflected the situation in the UK where independent contractors and pharmacy chains did not always work together to seek mutual goals. Indeed, the profession found it easier to work as one when

the focus was on the uncontroversial task of seeking new roles for pharmacists who wished to pursue them and not on removing the barriers to integration with primary care. This is because the wide-scale reorganisation of pharmaceutical services could threaten the businesses of many pharmacists who were happy to focus primarily on dispensing. Therefore, the profession was in danger of protecting a *status quo* that kept community pharmacists separated from patients, the facilities needed to treat them and (most importantly) their medical records.

Inertia

Fully aware of the inertia holding the evolution of pharmacy back, Hepler and Strand suggested a new way forward where the focus was on the well-being of patients, as well as the potential benefits for pharmacists. However, the authors

warned that pharmacists following their advice must be able to work with other professions. In particular, they believed that the goal should be effective co-operation with physicians and nurses as professional equals. Successfully achieving this aim required mutual co-operation with others while maintaining autonomy for the pharmacist.

However, this seemingly reasonable call for inter-professional working failed to address the important issues of appropriateness and efficiency. In regard to the former, Hepler and Strand believed that pharmacists had a comparative advantage in providing pharmaceutical care because of their training. Regarding the latter, they did little to explore whether physicians, nurses or other groups could provide such services more economically.

Although appropriateness and efficiency may seem side issues given the massive benefits patients could derive from proper pharmaceutical care, they shaped the foundations of the 2000 pharmacy plan. For instance, the extra money provided for medicines management (in particular, Medicine Use Reviews) was “ring-fenced” as part of the new contract for pharmacists, so each contractor was guaranteed their own share.

Competitive bidding

Alternatively, money could have been added to PCT budgets locally so that practices, pharmacists or alternative providers could have bid competitively to provide the required services. Therefore, Hepler and Strand’s concept was conservative in its conception and did not represent the radical departure from traditional professional roles that patients on multiple medicines probably required.

Hepler and Strand’s concept of pharmaceutical care was paradigm-shifting for pharmacy, but made little impact outside. Although there was general acknowledgement that the approach (often labelled as “medicines management” in the UK) was beneficial to patients, the ring-fencing of monies and the strict belief that only pharmacists possessed the necessary skills ham-

pered its progress. In a health service divided along professional lines and instituted to keep GPs and community pharmacists separate, the 2000 pharmacy plan failed to tear down the barriers to change.

However, Hepler and Strand had warned, pharmaceutical care is a necessary element of medical care. Pharmaceutical care must be integrated with other elements of care if it is to benefit the patient fully. Co-operation is complicated by the possibility that pharmaceutical care represents an expansion into the traditional roles of physicians and nurses.

Status quo

As this quote suggests, political imperatives and professional self-interest created a set of reforms that maintained the *status quo* in NHS prescribing and dispensing. Against this background, GPs were more likely to seek the advice of a PCT-employed pharmaceutical adviser, or to employ a practice-based pharmacist, than to engage with the reforms announced in the pharmacy plan. Therefore, the traditional act of prescribing was more important to patient management than the modern concept of pharmaceutical care. Indeed, prescribers were more likely to be guided by Parish’s concept of “rational prescribing” than to be influenced by Hepler and Strand’s pharmacist-centric paradigm.⁶

The 2000 pharmacy plan was the culmination of many years work and set the path for pharmacy reform to this day. However, in November 2013 the Director of Policy at the Nuffield Trust, Dr Judith Smith, produced a report with colleagues entitled *Now or Never: Shaping pharmacy for the future*.⁷ The document outlined the findings of the Royal Pharmaceutical Society’s Future Models of Care Commission, chaired by Dr Smith. The Committee’s approach to compiling its report was very similar to that adopted by the Nuffield Report in the mid-1980s.

The Commission’s conclusions set out a clear imperative for community pharmacists to shift their core activities away from dispensing towards service

provision. To accelerate the speed of this change, *Now or Never* made a number of policy recommendations, based upon the development of new models of care. In particular, the document suggested that commissioners be bold in purchasing innovative pharmacy services, with new technology freeing pharmacists from the dispensary.

However, Dr Smith and colleagues concluded that “Pharmacy is in some ways its own worst enemy, having spent over 20 years pointing out that it is under-utilised, writing plans and visions for the future, yet seeming unable to influence in a significant manner the commissioning and implementation of this alternative world.”

Indeed, the authors argued that too much time has been spent analysing future directions and action was thus required. Therefore, it is probably now or never for community pharmacists who wish to move away from dispensing in order to locate themselves as pharmaceutical care providers within mainstream primary care.⁸

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